The Potentially Suicidal Patient

Detection and Management in Office Practice

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IN THE UNITED STATES TODAY suicide is the tenth major cause of death. Each year about 20,000 people kill themselves. The actual rate, including victims who conceal a suicidal death or self-inflict death "by accident," may approach 50,000. About 60 percent of suicides have history of previous attempts and 10 percent of those who attempt suicide and survive kill themselves later. It is estimated that for every person who kills himself there are at least ten others who attempt and fail.[1] About half of all who kill themselves see a physician sometime during the month before. And most physicians see about six potentially suicidal patients each year, but rarely is the chief complaint elicited during the office visit, "I'm thinking of killing myself."

The signs of potential suicide are unfortunately very "soft." Even if they are aware of the signs, few busy clinicians view potential suicide as a killer to be ruled out in their long list of differential diagnosis. Yet tuberculosis, the twentieth greatest killer in this country,[2] and twelfth worldwide, is frequently considered in differentiation. How can the physician, faced with imposing statistics that convey the waste of human resources through suicide, better detect and manage the suicidal patient in office practice?

Suicidologists have devised a sophisticated Suicide Potential Rating Scale (SPRS) which provides a degree of reliability in assessing the suicidal potential of a given patient.* The depression scale of the Minnesota Multiphasic Personality Inventory (MMPI) is thought by some to provide the physician with an index of suspicion about the suicidal potential of some patients.† Although both the SPRS and the MMPI are instruments of value, they are used primarily by psychologists and psychiatrists or by physicians who have greater than usual interest in establishing a laboratory-like basis for treating the emotional aspects of illness. In other words, the busy clinician would use neither instrument frequently enough to warrant training in the use of the scales. As computerized record-keeping and information retrieval systems become more readily available to groups of individual physicians, these instruments or their refinements will be of immense value.

The MMPI is currently computerized for immediate use.‡ But until more physicians are ready to supplement clinical skill with computer-processed information, most of us will continue to assess suicidal risk wholly by means of clinical interview. To do this well, we must become acquainted with the varieties of suicidal behavior of individual patients.

This requires developing a little more patience than we often have, mastering more anxiety than we are often aware of, and, most important, believing that our responsibility in delaying death is not limited to diseases amenable to treatment by drugs and instruments. We need more patience because uncovering and evaluating suicidal thoughts can be a slow and circuitous process. We need to master our own anxiety because we physicians are

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†Minnesota Multiphasic Personality Inventory. Psychological Corporation, 304 East 45th Street, New York, New York 10017.

‡Roche Computerized Form of MMPI, Roche Psychiatric Service Institute, Box 170, Newark, New Jersey 07101.

not often comfortable with situations that challenge our effectiveness outside of our conventional roles. And we need take more responsibility because those of us who view suicide as a problem of theology, philosophy or personal conscience and not medicine, will probably convey such a view to the patient who seeks help. The physician aware of these requirements can do much to detect and manage a potentially suicidal patient.

The Potentially Suicidal Patient

The New Patient

When any patient appears for the first time in a physician's office for routine examination or with a myriad of vague complaints, the medical work-up should include an assessment of how the patient has dealt with stress in the past. This does not have to be done on the first visit, but if the physician's concern is aroused by factors which we will soon discuss, it is better to make the assessment as early as possible. For example, if after loss of a job, loss of a loved one, or loss of self-esteem, the patient's mourning, despair or apathy persisted with little relief for longer than six to twelve weeks,[3] the physician should re-explore the vague somatic complaints elicited in the patient's description of his present illness or in the systems review. If anxiety, weight loss, insomnia, fatigue, social withdrawal, and waning interest lingered long after the loss, the physician should determine whether this is characteristic of the patient's reaction to stress or whether it represents a newly emerging pattern of behavior.

Characteristic Reaction to Stress

If the physician infers that the behavior is of an old established pattern with this particular patient, he should tactfully explore past suicidal potential by honestly asking the patient how he overcame the specific stresses and whether he continues to dwell over them now. If the patient appears more uncomfortable at this point, the physician can gently, but matter-of-factly, confront the patient with his seeming discomfort. This confrontation may demonstrate to the patient that the physician can understand and discuss such discomfort.

If the patient denies past conflict or current discomfort, the physician can honestly state that as part of a thorough medical evaluation he wishes to know if the patient ever thought about suicide. Asking him does not plant the seeds of suicidal thoughts. In most cases, the character of the response will allow the physician to determine its

TABLE 1.—*Suicide Rate Per 1,000 Population Among 3,800 Suicides, by High- and Low-Risk Categories of Risk-Related Factors (reported by Tuckman and Youngman)*

Factor	*High-Risk Category*	*Suicide Rate*	*Low-Risk Category*	*Suicide Rate*
Age	45 yrs. and older	24.0	Under 45 yrs. of age	9.4
Sex	Male	19.9	Female	9.2
Race	White	14.3	Nonwhite	8.7
Marital status	Separated, divorced, widowed	12.5	Single, married	8.6
Living arrangements	Alone	48.4	With others	10.1
Employment status*	Unemployed, retired	16.8	Employed†	14.3
Physical health	Poor (acute or chronic condition in the six month period preceding the attempt)	14.0	Good†	12.4
Mental condition	Nervous or mental disorder, mood or behavioral symptoms including alcoholism	19.1	Presumably normal, including brief situational reactions†	7.2
Medical care (within 6 months)	Yes	16.4	No†	10.8
Method	Hanging, firearms, jumping, drowning	28.4	Cutting or piercing, gas or carbon monoxide, poison, combination of other methods, other	12.0
Season	Warm months (April-September)	14.2	Cold months (October-March)	10.9
Time of day	6:00 A.M. to 5:59 P.M.	15.1	6:00 P.M. to 5:59 A.M.	10.5
Where attempt was made	Own or someone else's home	14.3	Other type premises, out-of-doors	11.9
Time interval between attempt and discovery	Almost immediately, reported by person making attempt	10.9	Later	7.2
Intent to kill (self-report)	No†	14.5	Yes	8.5
Suicide Note	Yes	16.7	No†	12.3
Previous attempt or threat	Yes	25.2	No†	11.0

*Does not include housewives and students.

†Includes cases for which information on this factor was not given in the police report.

sincerity. If the patient's response is of genuine surprise or disbelief (accompanied with an "of course not!"), the index of suspicion is more often than not minimal, and the astute clinician can feel somewhat safer about this person's future suicidal risk. If the reaction is tenuous, guarded, with a change in voice, accompanied by an "I've never had the guts" response, the doctor's suspicion is obviously greater. It must be borne in mind, however, that with few exceptions a patient will relate quite honestly more profound suicidal feelings once the physician emphatically lets him know that they can be discussed. At this point some of the specific incidents in the patient's past might be discussed along with the suicidal ideas and feelings that accompanied those events.[4]

If the patient is found to have a past history of suicide attempts, the risk-related factors in suicides reflected in data reported by Tuckman and Youngman[5] (Table 1) are of special value. This may help the physician assess high and low risk related factors in his patient's history and clinical evaluation.

When it is apparent that a patient has considered suicide in the past, the following six areas of assessing future suicidal potential should be explored with him:

1. The frequency and extent of suicidal ideas.
2. The considered means of suicide accompanying the ideas.
3. The feelings associated with the means of suicide.
4. The available means by which the idea can be acted upon.
5. The feelings of suicide accompanying ordinary acts of everyday life.
6. The ability to project how loved ones would be affected by the patient's death.

The Frequency and Extent of Suicidal Ideas

If the patient relates a series of stressful situations, most of which were accompanied by frequent suicidal thoughts, recurring many evenings when he retired and persisting when he awoke most mornings, the physician should be more alert to the potential risk of suicide.

The Considered Means of Suicide Accompanying the Ideas

On the basis of the patient's extensive past suicidal thoughts, the physician should explore the means of suicide that the patient considered. This should be done by simply asking him, "How did you think of doing it?" This is particularly important if the patient has a family history of suicide or is profoundly depressed; if he is an alcoholic; if he is male, white, divorced, young, or over 65; if he is Protestant, unemployed, poor and if he has a chronic, long-standing but not necessarily disabling or debilitating disease. In other words, the physician's index of suspicion about a potential suicide increases as known factors of increasing suicidal risk accumulate in the patient's life history.[6] The potential is greater (with qualified exceptions) if the patient replies, "With a gun," than if he says he had considered pills or poison. Usually the suicidal potential can be considered greater if the fantasy of suicide was bizarre or violent.

The Feelings Associated With the Means of Suicide

If the patient relates particular means by which he thought of killing himself, the physician should explore the feelings accompanying those past thoughts. If the patient speaks of having been relieved by ideas of death rather than frightened or awed by them, the potential is again great. If he discloses having had overwhelming feelings or urges to use the gun or take the pills, and of willfully fighting these feelings to avoid actually obtaining the means, the potential is great. If he does not spontaneously discuss such items, the physician should ask, "Were you relieved or frightened at the thought of using the gun on yourself at those times? How intense were the feelings of wanting to use it? Did you have to literally leave what you were doing and do something else to avoid the feelings and thoughts?" If any of these questions are answered "Yes," the patient's suicidal potential is greater than usual. Since most formerly suicidally contemplative people rarely forget the profound intensity of such feelings, an "I don't remember" answer should be viewed with suspicion. If the questions are readily negated by the patient, the suicidal potential is lessened.

The Available Means by Which The Idea Can be Acted Upon

Clinically evaluating potential risk can be aided by an exploration of what actual means are readily available to the patient to carry out his suicidal thoughts. If in his suicidal fantasy a gunsmith elaborates upon the kind of shot, the size of the bore and the position of the gun, the past risk and

the potential are obviously serious. If a ruminative physician-patient with a drinking problem scoffs at the idea of an overdose of meprobamate because it would not do the job, but has had to avoid carrying vials of sodium luminal in his bag because of the synergistic activity of barbiturates and alcohol, one has reason to consider him a high risk patient. If a housewife's recurrent fantasy was of taking the 30 tablets or capsules of a sedative she had actually hidden under the mattress, one becomes concerned. Generally speaking, the risk of potential suicide increases to the extent to which the fantasied route of suicide is actually available in the patient's environment.

Feelings of Suicide Accompanying Ordinary Acts of Everyday Life

If the patient has been using a particular freeway exit for years, and, following a stressful event, entertained recurrent thoughts and desires to speed into the abutment, the risk is great. If a patient who for years had bathed while listening to a radio on a shelf above the bathtub, has recurrent urges to nudge the radio off the shelf, his potential for suicide is very great. If a housewife is increasingly preoccupied with placing her head in a gas oven which she had used for years without such thoughts, her suicidal potential is increased. In this area of assessment, one must be careful not to confuse the obsessional patient with the one whose feelings accompany the thoughts of suicide. It is the latter category that represents high risk. The obsessive patient, who may usually be recognized by his fastidiousness, may have recurrent thoughts of suicide or violence, but they are not usually accompanied by intense feelings. When such feelings accompany the thoughts, the compulsion to act can become more overwhelming and decidedly increase suicidal risk.

The Ability to Project How Loved Ones Would be Affected by the Patient's Death

It is important that the physician determine whether the patient has considered what his death would solve, how his loved ones would be affected, and who would carry on in his absence. If such considerations are strong deterrents, the patient's chances are good for overcoming suicidal feelings should they occur. Often the patient's need for immediate relief from the suicidal crisis obscures his ability to consider the welfare of those who would be affected by his death. When dealing with the currently suicidal patient, it is extremely important to stress this particular area of investigation. If he truly believes others would be significantly better off without him, that economic insecurity will be relieved by the benefits his death may provide and that his death solves a current stress, the potential suicidal risk is great.

Changing Reactions to Stress in a Patient Familiar to the Physician

The same criteria for suicidal potential apply to the person who is considering suicide for the first time. In most instances, the potential is less since it has not been a characteristic pattern of reacting to stress.[7] However, the patient's current emotional resources, the effectiveness of past means of coping with stress, and the frequency of factors increasing suicidal risk must be carefully evaluated. The physician cannot dismiss a patient whom he has known for many years and who he thinks is "stable," with a reassuring comment such as "I know you would never kill yourself." The same exploration of the extent and frequency of suicidal fantasies, fantasied means, intensity of feelings, available means, and the feelings accompanying everyday acts must be undertaken. Of special leverage to the physician in dealing with a patient he has known many years is the rapport of a long-term relationship, the knowledge of the patient's past effectiveness in handling stress, and the relationship of the patient to his family and job. An exploration of these areas very early, at the first signs of behavioral change, will be of far more benefit than the medication prescribed for vague somatic complaints with little organic basis.

Most physicians feel that an early assessment of suicidal potential will frighten the patient, cause him to view the medical interview as a "psychiatric" one, and to interpret the implications of the physician's concern as an intrusion. Nothing could be further from the feelings of someone who is weighing suicide as a solution to conflict. The ambivalent suicide-prone patient is immensely relieved to know that someone is available with whom to discuss the conflict. And the need to discuss it may be the overriding motivation behind the patient's office visit. This is not to suggest that the physician ask every patient during a routine examination whether he is currently or has in the past contemplated suicide, but only those whose life styles or current conflicts, considered with the clinical manifestations, indicate more exaggerated reactions to stress.

The Currently Suicidal Patient

Once the physician's suspicion is aroused, confirmed by the explanation of the patient's suicidal fantasies, and ambivalently acknowledged by a more relieved patient, the physician must determine where the patient fits among the following types of suicidal behavior[8]:

1. Transient ideas of death.
2. Sustained ideas and recurrent wishes of death.
3. Frustrated feelings and impulsive behavior.
4. The court of last resort.
5. The logical decision to die.

Transient Ideas of Death

This is the behavior characterized in Tom Sawyer's watching his own funeral. He mourns for himself and relishes the loss suffered by those who love him. This is a "they'll love me when I'm gone" type of fantasy experienced at some time by all of us and rarely indicative of significant suicidal risk. But in an emotionally unstable person the frequency of the transient death fantasy along with previously noted high risk factors should increase the physician's suspicion. And if the patient is an adolescent, the frequency is of special concern. Suicide is the third greatest cause of death among teen-agers. Teen-agers, like Tom Sawyer, are susceptible to transient ideas of death. And although few adults believe it after reading today's headlines, youngsters in an adult world have rather limited means of coping with loss or disappointment.[9]

Sustained Ideas and Recurrent Wishes of Death

This is the type of behavior which may be established some time after the patient experiences increasing transient fantasies of death. The development of this pattern can be better understood by likening it to evoking the pain of a toothache by pressing one's tongue against the tooth. The very act which induces pain seems to relieve or master the anxiety of pain by continually calling it into play. The act, tongue against tooth, can be viewed as a habit or characteristic style learned by the patient to cope with recurrent anxiety. That finds a parallel in the patient who moves from the transient death fantasy to the more sustained idea and recurrent wish of death. He has developed, one may say, a painful habit that permits him to relieve or master the anxiety of actual or anticipated stressful situations. The patient may shift back and forth from this behavioral type to the preceding one. And he can manipulate, often unwittingly, his environment or significant people in it by communicating his suicidal preoccupation. Here may be the patient who threatens suicide in a "non-serious" manner. But one cannot predict low risk on the basis of suicidal threat without attempt. The patient may readily slide into the next category of behavior but, before doing so, undergo a series of "furtive attempts." He may superficially cut his wrists in a futile effort to bleed. He may take a drug in less than lethal dose and find himself awake hours later. But, again, in crescendo with the previously noted risk factors, he may line up the pills, take them one at a time, and as his confusion increases, take one too many and die quite "by accident." Or, anticipating that someone will heed his "cry for help," he may miscalculate the whereabouts of a significant other person.

Frustrated Feelings and Impulsive Behavior

The suicidal potential in this form of suicidal behavior is even greater. The patient who feels he has "had it up to here" falls into this category. He sees little hope for support from his environment; he has supposedly exhausted most forms of relief and he feels frustrated and closer to anger than he would in the other forms of suicidal behavior. It has been theorized that such a person may turn upon himself the anger he feels toward others. It is this patient who runs the danger of the homicidal-suicidal act, and it is necessary for the physician to determine the degree of anger felt by the patient toward others. There is little data from which to predict the potential for both homicide and suicide, but the homicidal-suicidal pattern occurs more frequently among men than women.[10] Timely intervention with such a patient can be life-saving. By offering a means through which the patient can turn his rage into words, the physician helps him minimize the immediate impulse to act.

The Court of Last Resort

The patient who feels he has exhausted all emotional resources but has survived the anger and frustration of the previously discussed behavior may turn to a pattern that can be called a "court of last resort" attitude. His suicidal potential remains high since his rage, frustration, and despair are resolved, and he vows never to experience them again. His motivation to act is generally higher because he feels better. So at the slightest

suggestion of stress, he would rather die than experience again the anguish of meeting it. This is the patient who may be within the "three-month danger period" following a prolonged depression. So the physician must be alert to the very high potential risk in the patient who has survived the rage of the preceding type of suicidal behavior. The physician cannot be lulled into complacency by the patient's apparent well-being. If he provides the patient with sleeping medication because the suicidal preoccupation apparently has passed, he risks giving him a more effective means of acting suicidally should he become less ambivalent. The "court of last resort" type of suicidal behavior perhaps results in the most deaths, topped only by the previously described "frustrated feelings and impulsive behavior."

The Logical Decision to Die

Some patients may view death as the logical solution to a current conflict. Patients of either sex, over 65 years of age, who have suffered loss of loved ones, who have chronic disease or terminal illness, fall into this category. A large proportion of physician suicides may be of the "logical decision" order, although not apparently so in life since signs and symptoms of conflict are frequently masked or denied. The college student who philosophically arrives at death as an inevitability "so why not now?" can be seen in this form of suicidal behavior. Many patients of this category, when they do see a physician, may impart their torment to him only through physical symptoms. And it is difficult to identify the very high risk patient in this category simply from clinical signs. Here, especially, one has to consider the interplay of factors such as age, sex, occupation, marital status and many others. Fortunately, although this is the highest risk category of suicidal behavior, few people fall within it.

Management of the High Risk Patient

When the physician is concerned about suicidal risk in a patient he knows, he should always consider suicidal portent within the differential diagnosis if, during an office visit, the patient has exaggerated reactions to stress or complains of vague, non-specific symptoms. At the time of stress, management entails an honest evaluation of the problem, as outlined in earlier paragraphs of this communication. The physician should tell the patient of his concern over the suicidal implications and emphasize the necessity of a return office visit.

Most physicians feel they do not have the time or the skill to cope with such a patient. However, elaborate though the detection process described in the early part of this presentation may seem, it should add no more than 15 minutes to a routine or initial office examination — certainly not too much extra to allot to new patients or to the half-dozen potentially suicidal who might be seen in a year. As for skill, a physician who bears in mind that the suicidal patient needs a non-judgmental, caring person with whom to discuss his immediate feelings and not necessarily a psychiatrist to ascertain the ultimate "cause" of these feelings, can do much to help the patient dissipate his self-destructive tendencies.

The follow-up visit need be no longer than 15 or 20 minutes. It should be scheduled by the physician while the patient is in the office. The physician should firmly establish that he is concerned with the patient's problem by instructing his secretary, in the patient's presence, to "schedule Mr. Jones from 3:30 to 3:50 Wednesday afternoon in my consultation room." Such direct instruction to the secretary personalizes the physician's attitude and temporarily divests the patient of any indignity he may feel. It also tells him the length of time allotted for discussion of his conflict, which makes it easier for the physician to end the follow-up visit.

If the suicidal risk is very grave, the physician will obviously wish to see the patient within a few days, but if the risk appears to be relatively low, the patient can be seen 20 minutes a week for six weeks, that being the usual duration of emotional crisis or reaction to loss. Fewer than six visits will suffice in some cases; often it will be necessary to see the patient over a longer period.

Listening, and Getting the Patient to Talk

To communicate with the patient, first of all one must listen. Often without much prompting the patient will tell the physician what he needs to know for the assessment of risk. When it is necessary to intervene with a silent patient the physician should matter-of-factly and empathically call attention to the non-verbal clues the patient communicates. For example, "You seem to sit much lower in that chair today," or, "You're really going to town on that cigarette." Confronting the patient with the non-verbal way in which he communicates

his feelings permits him to see the physician as someone he may discuss these feelings with. The skill here is obviously in the art of medicine and requires that the physician "read" the patient in such a way as to minimize the risk that the doctor's remarks will be misperceived as an accusation. If they are misperceived, however, the physician has an opportunity to gently wonder aloud whether the patient may not be grouping him along with everything else that is bad in the patient's world. In other words, intervention should be for the purpose of encouraging productive ventilation on the part of the patient. But the physician cannot remain inactive with the potentially suicidal patient.

After five or ten minutes of such ventilation, the physician must re-explore suicidal preoccupations the patient has had since the last visit. Exploration of the stressful situation preceding the suicidal thoughts should be resumed. Special concern should be paid to the extent to which the patient's feelings associated with the means of suicide have changed. If he has a stronger feeling about killing himself by means of a readily available weapon or drug, one's concern is heightened. In such a situation the physician might wonder with the patient whether a family member should be apprised of the seriousness of the patient's condition. In most cases, the patient who appears relieved at such a suggestion is prognostically better off than one who discourages it. For the patient who can effectively fall back on the emotional resources of family or friends, the suicidal risk is reduced. If the patient refuses to involve his family, however, the physician can convey his persistent concern to the patient by asking him if he would object to the physician's discussing the patient's difficulty with a psychiatric colleague — this rather than a direct suggestion of psychiatric consultation. Such an intervention minimizes feelings of rejection and further loss that the high risk patient may experience at the suggestion that he see someone else.

The physician's tact and concern can establish for the patient a relationship by which he can find his way back to a life he is not sure he wants. The visit should end with the physician pointing out areas in which the patient seems to be finding his way back. If the patient's feelings have diminished in intensity, or if he has, say, disposed of a supply of a lethal drug, the physician should carefully reinforce such behavior.[11] A remark as simple as, "Getting rid of the pills is more than you could do last week," is often of value. Any indications that the patient has made efforts toward socialization, or that his appetite or sleeping patterns have improved or that he is brooding less are a sign of decreasing risk and should be emphasized at the end of the office visit.

The time between visits is obviously crucial to the high risk patient. At each visit the physician should reassure the patient—and not falsely—that at any time of frightening suicidal thoughts or feelings, the physician is available by phone. Some physicians may view this suggestion as an open invitation to many sleepless nights. It can be, but in most cases the patient does not exploit this privilege within the relationship. Often the very fact that the patient knows he can call diminishes the intensity of his suicidal feelings.[12]

Drug Therapy

As was previously noted, depression is not among the clinical characteristics of one of the higher risk categories of suicide-potential behavior. However, when depression is clinically evident (especially in a non-schizophrenic patient with long history of intermittent depression and little evidence of a stress-precipitating event within the preceding two or three months) a trial of imipramine, 150 to 250 mg a day for three weeks, is indicated. The advantages of using "faster-acting" desmethyl derivatives of imipramine or amitriptyline are still equivocal. The same may be said of dextroamphetamines. Sometimes a suicidally depressed patient may respond in less than three weeks, but so will some who take no antidepressants. If there is little evidence of decreased depression after three weeks of adequate dosage of imipramine (and in the absence of excessive side effects) it should be discontinued and, after a two-week interval, a monoamine oxidase inhibitor may be tried. (There are reports from England indicating that monoamine oxidase inhibitors and imipramine may be used synergistically for more effective antidepressant action, but in the pharmaceutical literature in this country the combination is associated with adverse side effects and fatalities.) Even if the depression is alleviated by use of the drugs, one must still bear in mind that the suicidal risk is not necessarily minimized thereby, as the three-month post-depression danger period is still to be considered.

The question of drugs to induce sleep in a suicidal patient is always a difficult one.[13] The physician is often convinced that a good night's sleep

would strengthen a patient's will to live. Yet recent studies[14] suggest that sleeping medications, although extending the period of sleep, may decrease dreaming which is looked upon as psychologically necessary. Nevertheless, a widely tolerated sleeping medication (prescribed in small quantities to discourage "hoarding" for a suicide attempt) can be helpful. The lethal range of barbiturates is variable, and they react quite synergistically with alcohol and neuroleptic agents. Chloral hydrate remains the safest sleeping medication. When more potent ones appear necessary for a high risk patient, the physician should caution the family as to their use and danger and arrange for a family member to dispense the medication. If this arrangement cannot be made, psychiatric consultation and putting the patient into a hospital for immediate crisis may be necessary. In any event, if over a period of six or more visits the patient's suicidal potential becomes greater, or if the physician's anxiety is heightened and his patience exhausted, psychiatric consultation is indicated, but this should be rare.

REFERENCES

1. Hendin, Herbert, M.D.: Psychiatric emergencies; *From* Comprehensive Textbook of Psychiatry, Edited by A. M. Freedman, M.D. and H. I. Kaplan, M.D., Williams and Wilkins Company, Baltimore, 1967, pp. 1170-1172.

2. Deaths and Death Rates for Selected Causes: National Center for Health Statistics, Public Health Service, U.S. Department of Health, Education and Welfare; *From* the World Almanac 1968, Newspaper Enterprises Association, Inc., New York, p. 895.

3. Parkes, C. Murray: Bereavement and mental illness, Brit. J. Med. Psychol., 38:1-12, Part 1, Mar. 1965.

4. Ross, Mathew: The presuicidal patient: recognition and management, South. Med. J., 60:1094-1098, Oct. 1967.

5. Tuckman, J., and Youngman, W. F.: A scale for assessing suicide risk of attempted suicides, J. Clin. Psychol., 24:17-19, Jan. 1968.

6. Litman, Robert E.: Emergency responses to potential suicide, J. Mich. St. Med. Soc., 62:68-72, Jan. 1963.

7. Yamamoto, J., Lipson, L., and Litman, R.: A comparison of committed suicides in Los Angeles County in 1963 and 1966 previously treated at the Los Angeles County General Hospital (Unpublished Paper).

8. Devries, A. G.: Definition of suicidal behavior, Psychol. Rep., 22:1093-1098, June 1968.

9. Teicher, J. D., and Jacobs, J.: Adolescents who attempt suicide, Amer. J. Psych., 122:1248, Nov. 1966.

10. Pokorny, Alex D.: Human violence—a comparison of homicide, aggravated assault, suicide, and attempted suicide, Journ. Crim. Law, Criminol. and Police Sci., 56:488-497, Apr. 1965.

11. Bodie, M. K.: When a patient threatens suicide, Perspect. Psychiatr. Care, 6:76-79, June 1968.

12. Kaphan, M., and Litman, R. E.: Telephone appraisal of 100 suicide emergencies, Amer. J. Psychother., 16:595-599, June 1962.

13. Lewis, Jerry M.: The family doctor and the suicidal crisis, Texas Med., 64:52-56, Jan. 1968.

14. The UCLA interdepartmental conference: Sleep and dreams, recent research on clinical aspects, Moderator: Kales, A. Discussants: Beall, G. N., Berger, R. J., Heuser, G., Jacobson, A., Kales, J., Parmelee, A. H., and Walter, R. D., Ann. Int. Med., 68:1078-1104, May 1968.

CYSTOPERINEAL FISTULA

How would you treat a male who developed a cystoperineal fistula following abdominoperineal resection for rectal cancer?

"I would do my complete urologic investigation; I would want to double check where the fistula was in the bladder; and here it would probably be in the trigone or even more likely in the urethra. I would double-double check that by chance the ureter had not been severed, and that the outflow of urine was not from an unrecognized ureteral injury. Having done all that and assuming that it would be between the urethra or the trigone, I believe that I would just go in and cut it out and sew it up.

"I might try to do it through a perineal approach for the obvious reason that the perineal approach gives you pretty good visualization if it's 'way low down. I would not be reluctant to do it transvesically. I believe on one or two occasions under such circumstances we have done both above and below. I would certainly divert the urine by an appropriate cystostomy. I would try to use very meticulous, fastidious technique as I tried to close the fistula, and I think I would have a fair chance of doing it."

—HARRY M. SPENCE, M.D., Dallas

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